Filing at a Glance

Company:	QualChoice Life and Health Insurance Company, Inc.
Product Name:	MediQ65
State:	Arkansas
TOI:	MS05I Individual Medicare Supplement - Standard Plans
Sub-TOI:	MS05I.015 Multi-Plan
Filing Type:	Form
Date Submitted:	08/17/2012
SERFF Tr Num:	QUAC-128648098
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	
Implementation Date Requested:	On Approval
Author(s):	Jim Couch, Liz Hubbard
Reviewer(s):	Stephanie Fowler (primary)
Disposition Date:	08/24/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: Arkansas **Filing Company:** QualChoice Life and Health Insurance Company, Inc.

TOI/Sub-TOI: MS05I Individual Medicare Supplement - Standard Plans/MS05I.015 Multi-Plan
Product Name: MediQ65
Project Name/Number: /

General Information

Project Name:
Project Number:
Requested Filing Mode:
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Jim Couch

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 08/24/2012
State Status Changed: 08/24/2012
Created By: Jim Couch
Corresponding Filing Tracking Number:

Filing Description:

This application will **replace** the previously approved by AID earlier this month. There were omissions in the previously filed application with respect to language for the Genetic Information Non-Discrimination Act (GINA).

Company and Contact

Filing Contact Information

Jim Couch, VP of Compliance
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211

jim.couch@qualchoice.com
501-228-7111 [Phone] 5118 [Ext]
501-707-6729 [FAX]

Filing Company Information

QualChoice Life and Health Insurance Company, Inc.
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211
(501) 228-7111 ext. [Phone]

CoCode: 70998
Group Code:
Group Name:
FEIN Number: 71-0386640

State of Domicile: Arkansas
Company Type: Life & Health
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $50.00
Retaliatory? No
Fee Explanation:
Per Company: No

Company	Amount	Date Processed	Transaction #
QualChoice Life and Health Insurance Company, Inc.	$50.00	08/17/2012	61775149

SERFF Tracking #:	*QUAC-128648098*	***State Tracking #:***		***Company Tracking #:***	

State:	*Arkansas*	***Filing Company:***	*QualChoice Life and Health Insurance Company, Inc.*
TOI/Sub-TOI:	*MS05I Individual Medicare Supplement - Standard Plans/MS05I.015 Multi-Plan*		
Product Name:	*MediQ65*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	08/24/2012	08/24/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Stephanie Fowler	08/17/2012	08/17/2012

Response Letters

Responded By	Created On	Date Submitted
Jim Couch	08/23/2012	08/23/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Modified QualChoice MediQ65 Application	Note To Reviewer	Jim Couch	08/17/2012	08/17/2012

SERFF Tracking #:	*QUAC-128648098*	***State Tracking #:***	***Company Tracking #:***

State:	*Arkansas*	***Filing Company:***	*QualChoice Life and Health Insurance Company, Inc.*
TOI/Sub-TOI:	*MS05I Individual Medicare Supplement - Standard Plans/MS05I.015 Multi-Plan*		
Product Name:	*MediQ65*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 08/24/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Form (revised)	MediQ65 Application for Coverage	Approved-Closed	Yes
Form	MediQ65 Application for Coverage	Replaced	No

SERFF Tracking #: QUAC-128648098 **State Tracking #:** **Company Tracking #:**

State: Arkansas **Filing Company:** QualChoice Life and Health Insurance Company, Inc.

TOI/Sub-TOI: MS05I Individual Medicare Supplement - Standard Plans/MS05I.015 Multi-Plan

Product Name: MediQ65

Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	08/17/2012
Submitted Date	08/17/2012
Respond By Date	09/17/2012

Dear Jim Couch,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- MediQ65 Application for Coverage, 1110MK007_02 (Form)

Comments: The language looks fine, just wanted to point out a typo in the first sentence. It currently reads "... do no include...".

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

SERFF Tracking #:	*QUAC-128648098*	***State Tracking #:***	***Company Tracking #:***

State:	*Arkansas*	***Filing Company:***	*QualChoice Life and Health Insurance Company, Inc.*
TOI/Sub-TOI:	*MS05I Individual Medicare Supplement - Standard Plans/MS05I.015 Multi-Plan*		
Product Name:	*MediQ65*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	08/23/2012
Submitted Date	08/23/2012

Dear Stephanie Fowler,

Introduction:

Response 1

Comments:

We have made the correction to the application to fix this typographical error.

Related Objection 1

Applies To:

- MediQ65 Application for Coverage, 1110MK007_02 (Form)

Comments: The language looks fine, just wanted to point out a typo in the first sentence. It currently reads "... do no include...".

Changed Items:

No Supporting Documents changed.

SERFF Tracking #: QUAC-128648098 **State Tracking #:** **Company Tracking #:**

State: Arkansas **Filing Company:** QualChoice Life and Health Insurance Company, Inc.
TOI/Sub-TOI: MS05I Individual Medicare Supplement - Standard Plans/MS05I.015 Multi-Plan
Product Name: MediQ65
Project Name/Number: /

Form Schedule Item Changes

Item No.	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments	Submitted
1	1110MK007_02	AEF	MediQ65 Application for Coverage	Initial		MediQ65 Application Revised 8 16 12.pdf, MediQ65 Application Revised 8 23 12.pdf	Date Submitted: 08/23/2012 By: Jim Couch
Previous Version							
1	*1110MK007_02*	*AEF*	*MediQ65 Application for Coverage*	*Initial*		*MediQ65 Application Revised 8 16 12.pdf*	*Date Submitted: 08/23/2012 By: Jim Couch*

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Jim Couch

State: *Arkansas* **Filing Company:** *QualChoice Life and Health Insurance Company, Inc.*

TOI/Sub-TOI: *MS05I Individual Medicare Supplement - Standard Plans/MS05I.015 Multi-Plan*

Product Name: *MediQ65*

Project Name/Number: */*

Note To Reviewer

Created By:

Jim Couch on 08/17/2012 10:20 AM

Last Edited By:

Stephanie Fowler

Submitted On:

08/24/2012 01:31 PM

Subject:

Modified QualChoice MediQ65 Application

Comments:

You previously approved QCLHIC's modified Medigap application. I have determined that language was omitted from that application to address the Genetic Information Non-Discrimination Act (GINA). We have modified the previoulsy approved application in three (3) places to add this language regarding QualChoice not using or asking for genetic information as part of its medical questions. In order to make your review easier, we have hilighted in **yellow** those parts of the application that have been added. No other changes have been made to the previously approved application.

Please let me know if you have questions.

SERFF Tracking #:	*QUAC-128648098*	***State Tracking #:***		***Company Tracking #:***	

State:	*Arkansas*	***Filing Company:***	*QualChoice Life and Health Insurance Company, Inc.*
TOI/Sub-TOI:	*MS05I Individual Medicare Supplement - Standard Plans/MS05I.015 Multi-Plan*		
Product Name:	*MediQ65*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: 1110MK007_02

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 08/24/2012	1110MK007_02	AEF	MediQ65 Application for Coverage	Initial:		MediQ65 Application Revised 8 16 12.pdf MediQ65 Application Revised 8 23 12.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Application for Coverage

MediQ65® Medicare Supplement Insurance

Thank you for your interest in the QualChoice MediQ65® for your Medicare Supplement insurance coverage. You must be age 65, a resident of the State of Arkansas, and have both Medicare Part A and Medicare Part B to apply for MediQ65® coverage.

Please read the following information carefully to assure prompt processing of your application. A MediQ65® Application is also available at **www.mediq65.com.**

1. Complete this form yourself or with the help of an agent/broker authorized to sell QualChoice MediQ65® policies.
2. Answer each required question completely using dark blue or black ink. No pencil please.
3. Do not use liquid paper, correction tape or "white out" to correct any mistakes. If you make a mistake, mark through the incorrect information, initial it and then provide the correct information.
4. Complete all required sections to avoid delays in processing.
5. Sign and date the application as well as any attached sheets.
6. Keep a photocopy of this completed application and any attachments for your records.
7. Submit a voided blank check with the application if you want Monthly Bank Draft as your payment method. If electing monthly billing as your payment option, **DO NOT** send money with this application. You will be billed later.
8. Return this entire application and any attachments in the postage-paid return envelope provided. If certain sections do not apply to you, indicate so on the application.

NOTE:

- This application is a legal document, which will become part of your contract if you are approved for coverage. It is very important that you provide all requested information and that it is accurate and legible.
- The information provided here will be used and disclosed only as permitted by our *Notice of Privacy Practices* which can be viewed at **www.mediq65.com**.
- In answering the questions in this application, do no include any medical history or information related to genetic testing, services or counseling. Also, do not include any information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.

Policy Effective Dates

The policy effective date will be the 1st of the month after your application is approved and processed. Effective date of coverage cannot be:

- Prior to your Medicare Part A and Part B effective dates.
- Prior to your termination from a Medicare Advantage plan.
- Prior to your application submission date.

Question or Need Assistance?
Contact a MediQ65® Sales Manager
501.228.7111 or 855.633.4765 (855.MEDIQ65)
Monday-Friday 8 a.m. to 5 p.m.

SECTION I. WHO IS APPLYING

First Name	MI	Last Name	Gender	Date of Birth	Social Security Number

Primary Phone Number ( )	Secondary Phone Number ( )	Best Time to Call AM PM

Mailing Address	City	State **AR**	Zip Code	County
Billing Address (only if different from mailing address)	City	State **AR**	Zip Code	
Residential Address (only if different from mailing address)	City	State **AR**	Zip Code	

IMPORTANT DECISION:

I want to do my part for the environment and reduce waste. By checking **YES** below**,** I agree that QualChoice can deliver all documents, notices and any other communications with respect to my MediQ65® coverage electronically to my email address below. This includes, but is not limited to, my Insurance Certificate of Coverage, all explanation of benefits describing how my claims have been adjudicated, billing invoices, renewal notices, and any other communications. I understand I can change my mind at any time and revoke my decision to have these documents and communications sent to me electronically simply by contacting QualChoice at 1.855.MEDIQ65 (1.855.633.4765). I also understand that I can ask QualChoice at any time to provide me with any of these documents in paper form by regular mail. I agree to contact QualChoice if my email address changes so that these important documents, notices and communications will come to my new email address.

☐ **Yes** ☐ **No** **E-Mail Address**_____

SECTION II. ELIGIBILITY INFORMATION

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans.

Please answer all questions and include a copy of the notice from your prior insurer with this application.

Please check *(✓)* **YES** or **NO**

SECTION II. ELIGIBILITY INFORMATION

1. Did you turn age 65 in the last 6 months? ☐ YES ☐ NO
   a. Did you enroll in Medicare Part B in the last 6 months? ☐ YES ☐ NO
   b. If **YES**, what is the effective date? (MM/DD/YYYY) _____

2. Are you covered for medical assistance through the state Medicaid program?
   NOTE TO APPLICANT: If you are participating in a Spend-Down Program and have not met your Share of Cost, please respond **NO** to this question ☐ YES ☐ NO
   a. If **YES**, will Medicaid pay your premiums for this Medicare supplement policy? ☐ YES ☐ NO
   b. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium? ☐ YES ☐ NO

3. If you had coverage from any Medicare plan, other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO, PPO or PFFS), fill in your **START DATE** and **END DATE** below. If you are still covered under this plan, leave the **END DATE** blank.

   START DATE (MM/DD/YYYY)_____ **END DATE (MM/DD/YYYY)** _____

4. If you are still covered under the other Medicare plan. Do you intend to replace your current coverage with this new Medicare supplement policy? ☐ YES ☐ NO
   a. Was this your first time in this type of Medicare plan? ☐ YES ☐ NO
   b. Did you drop a Medicare supplement policy to enroll in the Medicare plan? ☐ YES ☐ NO
   c. Did you move out of the service area of your Medicare Advantage plan? ☐ YES ☐ NO
   d. Did your Medicare Advantage plan terminate its contract with CMS, cease to provide all services, violate its contract or otherwise notify you that you were losing coverage and eligible for guarantee issue into a Medigap policy? ☐ YES ☐ NO

5. Do you have another Medicare supplement policy in force? ☐ YES ☐ NO
   a. If **YES**, what is the name of the company? _____ Name of Plan? _____
   b. If **YES**, do you plan to replace your current Medicare supplement policy with this MediQ65 policy? (Please contact the MediQ65® Sales Manager to request the ***Notice of Replacement Questionnaire***.) ☐ YES ☐ NO

6. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan?) ☐ YES ☐ NO
   a. If **YES**, please list name of carrier. _____
   b. If **YES**, What are your dates of coverage under the other policy? If you are still covered under the other policy, leave **END DATE** blank.

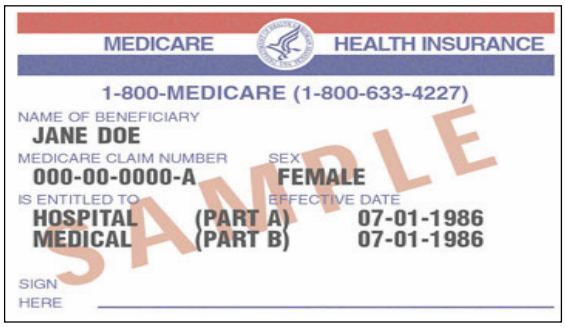
   START DATE (MM/DD/YYYY) _____ **END DATE (MM/DD/YYYY)** _____

SECTION III. YOUR MEDICARE INSURANCE INFORMATION

You must have both Medicare Hospital (Part A) and Medical (Part B) coverage to apply for MediQ65®

Please FILL IN THE BLANKS below to match your red, white and blue Medicare Health Insurance card.

Medicare Number	Hospital (**Part A**) Effective Date MM/DD/YYYY)	Medical (**Part B**) Effective Date (MM/DD/YYYY)



SECTION IV. CHOOSE YOUR PLAN.

Check (✓) only one.

Please enroll me in the following MediQ65® Plan:	MediQ65® Plan A ☐	MediQ65® Plan F ☐	MediQ65® Plan G ☐	MediQ65® Plan N ☐

Do you currently have QualChoice health coverage? ☐ No ☐ Yes

If **YES**, please write your QualChoice ID No. below

ID No. _____

IMPORTANT INFORMATION!

Please read carefully before continuing the application process.

Open Enrollment Period

Under the OPEN ENROLLMENT PERIOD health questions are not required to be answered. You are **NOT** required to complete Sections V-VIII if you are applying during the Medicare Supplement Open Enrollment Period. Please continue your application process at Section IX.

If You Are **NOT** in the Open Enrollment Period

Please answer ALL of the following health questions. Acceptance of your application is subject to your enrollment in Medicare Hospital (Part A) and Medical (Part B) coverage, Arkansas residency and our review of your answers to the medical questions. Your application cannot be processed unless all questions are answered.

SECTION V. PRIMARY CARE PHYSICIAN INFORMATION

Complete Name and Address of Physician	Date of Last Visit	Reason for Visit

SECTION VI. MEDICAL QUESTIONS

Please answer all questions if this section applies to you.

Please check (✓) either **YES** or **NO**.

1. What is your height? _____ft _____in

2. What is your weight? _____lbs

3. Are you Medicare disabled? ☐ YES ☐ NO
   If **YES**, please indicate disability condition(s) below.

4. Have you ever been declined or rejected for the issuance of life, accident, health or long term care insurance? ☐ YES ☐ NO
   a. If **YES,** Name of Carrier _____Year_____
      Reason_____

5. Have you used any form of tobacco within the past 12 months? ☐ YES ☐ NO
   a. If **YES**, Type of Tobacco _____Amount of Use _____

6. In the **last 5 years** have you:
   a. Had home health care services for any reason? ☐ YES ☐ NO
      If **YES,** please explain:

   b. Required the assistance of any other individual for performances of any activities of daily living? ☐ YES ☐ NO

      If **YES**, please check all that apply:
      ☐ Bathing ☐ Dressing ☐ Transferring ☐ Eating ☐ Toileting ☐ Continence

   c. Used any addictive or non-addictive drug or substance except as provided by a physician? ☐ YES ☐ NO

      If **YES**, please explain:

   d. Used alcohol in amounts greater than 3 drinks per day? ☐ YES ☐ NO

SECTION VI. MEDICAL QUESTIONS

Please answer all questions if this section applies to you.

7. Have you:

a. Ever had inpatient or outpatient cardiac surgery or other cardiac procedures? ☐ YES ☐ NO

b. Ever been diagnosed and/or treated for cancer (other than skin cancer)? ☐ YES ☐ NO

c. Been hospitalized since turning age 65? ☐ YES ☐ NO

If **YES**, how many total days were you in the hospital? No. of Total Days _____

SECTION VI. MEDICAL QUESTIONS (cont'd)

In answering the questions in this application, do no include any medical history or information related to genetic testing, services or counseling. Also, do not include any information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.

Give full details in Section VII: ADDITIONAL MEDICAL INFORMATION for each question checked below. Each question must have at least one box checked – if none of the the conditions apply; you must check 'None of the Above' on each question.

In the past three (3) years have you been treated for or been told you had:

8. **BRAIN OR NERVOUS SYSTEM DISORDERS**

- ☐ Alzheimer's disease or senile dementia
- ☐ Amyotrophic lateral sclerosis (ALS - Lou Gehrig's disease)
- ☐ Convulsion, epilepsy or seizures
- ☐ Meningitis
- ☐ Multiple sclerosis, muscular dystrophy or myasthenia gravis
- ☐ Neuritis or Polyneuritis
- ☐ Paralysis or palsy
- ☐ Parkinson's disease
- ☐ Vertigo, fainting or dizziness
- ☐ Any other disorder of the brain or nervous system
- ☐ None of the above

9. RESPIRATORY

- ☐ Chronic obstructive pulmonary disease or asthma
- ☐ Obstructive or reactive airway disorder
- ☐ Home oxygen therapy
- ☐ Any other disorder of the lungs, bronchial tubes or respiratory system
- ☐ None of the above

SECTION VI. MEDICAL QUESTIONS (cont'd)

In answering the questions in this application, do no include any medical history or information related to genetic testing, services or counseling. Also, do not include any information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.

Give full details in Section VII: ADDITIONAL MEDICAL INFORMATION for each question checked below. Each question must have at least one box checked – if none of the the conditions apply; you must check 'None of the Above' on each question.

In the past three (3) years have you been treated for or been told you had:

- ☐ Cirrhosis, hepatitis
- ☐ Crohn's disease or ulcerative colitis
- ☐ Diverticulitis
- ☐ Gastric bypass surgery or other weight loss procedure
- ☐ Gastric or duodenal ulcer
- ☐ Irritable bowel syndrome
- ☐ Gastric esophageal reflux disorder (GERD)
- ☐ Pancreatitis
- ☐ Any other disorder of the stomach, intestines, liver, gallbladder or rectum
- ☐ None of the above

11. EARS/EYES/NOSE/THROAT

- ☐ Cataracts or glaucoma
- ☐ Any other disorder of the eyes, ears, nose, throat or esophagus
- ☐ None of the above

12. GLANDULAR

- ☐ Adrenal disorders
- ☐ Diabetes, abnormal glucose
- ☐ Any other disorder of the pancreas, thyroid, pituitary, adrenal or other glands
- ☐ None of the above

SECTION VI. MEDICAL QUESTIONS (cont'd)

In answering the questions in this application, do no include any medical history or information related to genetic testing, services or counseling. Also, do not include any information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.

Give full details in Section VII: ADDITIONAL MEDICAL INFORMATION for each question checked below. Each question must have at least one box checked – if none of the the conditions apply; you must check 'None of the Above' on each question.

In the past three (3) years have you been treated for or been told you had:

13. CIRCULATORY

- ☐ Angina, heart attack, myocardial infarction, arteriosclerosis, coronary artery disease, shunt placement and/or angioplasty
- ☐ Cerebrovascular accident (stroke) including transient ischemic attack (TIA)
- ☐ Chest pain, shortness of breath, heart murmur palpitation of the heart, rheumatic fever
- ☐ Heart bypass surgery, pacemaker implant
- ☐ Heart surgery
- ☐ High blood pressure
- ☐ Hemophilia
- ☐ Any other condition of the heart, blood, blood vessels or circulatory system
- ☐ None of the above

14. CANCER, LYMPHATIC SYSTEM, BLOOD, OR SKIN DISORDERS

- ☐ Anemia
- ☐ Cancer
- ☐ Hodgkin's disease
- ☐ Leukemia
- ☐ Melanoma, neoplasm or tumor
- ☐ Any other disorder of the lymphatic system
- ☐ Any other disorder of the skin
- ☐ None of the above

15. MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Chronic fatigue
- ☐ Connective tissue disorder
- ☐ Fracture(s) or broken bone(s) — Exposed bone? ☐ YES ☐ NO
- ☐ Fibromyalgia
- ☐ Lupus, systemic
- ☐ Any other disorder of the muscles, bones or joints
- ☐ None of the above

SECTION VI. MEDICAL QUESTIONS (cont'd)

In answering the questions in this application, do no include any medical history or information related to genetic testing, services or counseling. Also, do not include any information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.

Give full details in Section VII: ADDITIONAL MEDICAL INFORMATION for each question checked below. Each question must have at least one box checked – if none of the the conditions apply; you must check 'None of the Above' on each question.

In the past three (3) years have you been treated for or been told you had:

16. KIDNEY, URINARY, REPRODUCTIVE

- ☐ Abnormal pap smear
- ☐ Bladder or renal stones
- ☐ Dialysis
- ☐ Nephritis
- ☐ Nephrotic syndrome, renal disease or failure
- ☐ Sexually transmitted disease
- ☐ Sugar, blood or protein in urine
- ☐ Any other disorder of the reproductive organs, including prostate, ovaries or breasts
- ☐ None of the above

17. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE

- ☐ Anxiety, depression, emotional problems or nervous disorder
- ☐ Drug overdose
- ☐ Eating disorder
- ☐ Psychiatric treatment
- ☐ Any other mental, emotional disorder or situation
- ☐ None of the above

18. OTHER

- ☐ Current patient in a hospital or nursing home
- ☐ Sarcoidosis
- ☐ Any other implant(s), prosthetic device(s) internal fixation device(s) or retained hardware (i.e.. Pins, wires, screws, shunts, stents)
- ☐ Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder, or HIV
- ☐ Transplant recipient
- ☐ Surgery, procedure, or test advised by physician but not completed
- ☐ Unexplained or unintentional weight loss of 10 pounds or more
- ☐ Any injury deformity, incapacitation, disease or condition not listed elsewhere
- ☐ None of the above

SECTION VII. ADDITIONAL MEDICAL INFORMATION

1. Give full details to conditions checked in **Section VI, Questions 8-18**.
2. Include all treatments provided or planned that apply in the "Type of Treatment" section. Example treatments are:
   - Surgery Hospitalization
   - Emergency room visit
   - Chiropractic treatments
   - Nursing Home confinement
   - Doctor visits
   - Rehabilitation therapy (speech, physical, occupations)
3. Please ensure you include all the treatments that apply.
4. Indicate the name(s) that would have been given at the time of the physician visit-e.g. a maiden name.

NAME: _____

Question Number	Condition/Illness -and- Type of Treatment	Date of first Diagnosis		Date of Most Recent Visit		Total # of Visits	Degree of Recovery			Complete Name -and- Address of Physician
		MO	YR	MO	YR		None	Partial	Full	
15.	**Condition/Illness:** Arthritis **Type of Treatment:** Doctor Visit	8/10 **Mo Year**		6/12 Mo Year		8		X		Dr. XYZ 123 Any Street Any Place, AR
	Condition/Illness: Type of Treatment:	___/____ Mo Year		___/____ Mo Year						
	Condition/Illness: Type of Treatment:	___/____ Mo Year		___/____ Mo Year						
	Condition/Illness: Type of Treatment:	___/____ Mo Year		___/____ Mo Year						
	Condition/Illness: Type of Treatment:	___/____ Mo Year		___/____ Mo Year						
	Condition/Illness: Type of Treatment:	___/____ Mo Year		___/____ Mo Year						

SECTION VIII. PRESCRIPTION QUESTIONNAIRE

1. Are you currently taking any prescription medication, or have you taken prescription medication in the **last three (3) years**? ☐ YES ☐ NO

SECTION VII. ADDITIONAL MEDICAL INFORMATION

2. If you answered **YES**, please provide full details below. A print out from the pharmacy in **not** acceptable.

Name of Medication	Dosage	Specific Condition or Illness	Start Date (MM/YYYY)	Stop Date (MM/YYYY)	Degree of Recovery			Complete Name - and- Address of Physician
					None	Partial	Full	
Tylenol	1000 mg	Osteoarthritis	06/2008	Current	X			Dr. XYZ 123 Any Street Any Place, AR

SECTION IX: IMPORTANT INFORMATION FOR APPLICANT FORM

Carefully read and sign. Your application cannot be processed without this form being signed and returned.

Send no money with this application. You will be billed.

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. If, after purchasing this policy you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

IN SIGNING BELOW, I REPRESENT AND ACKNOWLEDGE

1. That I should not cancel any coverage I currently have until I am notified of QualChoice's decision.
2. An agent/broker involved in this insurance transaction may receive compensation from QualChoice for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent/broker.
3. If my application is accepted relying on my representations on this document, any coverage which may be issued to me shall be invalid if based on false information.
4. I agree any provider of medical services or supplies is authorized and directed to furnish QualChoice all records or copies thereof, relating to such services or supplies.
5. I authorize and release to QualChoice, Title XVIII Medicare claims information needed to coordinate benefits with this policy at any time I am eligible for Medicare benefits.
6. QualChoice may phone me for additional information that may help with the timely processing of my application.

IN SIGNING BELOW, I REPRESENT AND ACKNOWLEDGE

7. That the statements and answers given in this application and any signed and dated addenda to this application (both front and back) are true, complete and correctly recorded.
8. I have read and understand the **Important Information for Applicant** (Section IX).
9. I ACKNOWLEDGE my understanding that consistent with the requirements of the **Genetic Information Nondiscrimination Act of 2008**, QualChoice does not use genetic information for underwriting purposes or any other purpose prohibited by applicable law. I also acknowledge that QualChoice has requested that in answering the questions in the attached application I do not include any family medical history or information related to genetic testing, genetic services or genetic counseling. Also, QualChoice has requested that I do not include information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information. I further acknowledge that QualChoice has directed me to omit or remove from the attached application any genetic information.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

- I, the applicant, certify that I signed this application in the state of Arkansas.
- I, the applicant or my authorized representative, acknowledge receipt of the following:
  - ☐ ***Choosing A Medigap Policy: A Guide to Health Insurance for People with Medicare*** (available at www.medicare.gov/publications) and ***Outline of Medicare Supplement Coverage*** from QualChoice.

SIGNATURE OF APPLICANT	**DATE SIGNED** (MM/DD/YYYY)

FOR AGENT / BROKER ONLY

If application is being made through an agent/broker, he/she must complete the following:

I have read and understand the MediQ65® ***Application for Coverage***. I additionally certify that the applicant has received the *Choosing A Medigap Policy: A Guide to Health Insurance for People with Medicare* and the *Outline of Medicare Supplement Coverage* for the policy applied for and that the applicant has Medicare Parts A and B. The policy applied for will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage.

Before this form can be processed, the agent/broker's current health and life license must be on file with QualChoice. In addition, the agent/broker must be appointed with QualChoice.

AGENCY FEDERAL TAX ID # (IF APPLICABLE)	**AGENT/BROKER LICENSE #**	**PHONE NUMBER**
AGENT/BROKER PRINTED NAME	**AGENT/BROKER SIGNATURE**	**DATE SIGNED** (MM/DD/YYYY)

List below all health insurance policies you have issued to this applicant that are still in force and any other health insurance issued in the past five (5) years that are no longer in force and submit with this application as required.

NAME OF POLICY	NAME OF INSURANCE COMPANY	POLICY DATE (MM/DD/YYYY)	
		To	From

SECTION X: AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) FORM

Your application cannot be processed without this form being signed and returned.

1. I authorize any medical professional, medical care institution, other provider of health care services or supplies, the Medical Information Bureau (MIB), reinsurer, health plan, prior insurance carrier, consumer reporting agency, other third party medical and/or pharmaceutical databases or other organization, institution or person, that has any records on me or my health to provide QualChoice, any third party retained by QualChoice, or its reinsurers, information with respect to any physical or mental condition, treatment or any non-medical information on me.
2. I understand that information obtained as a result of this authorization will be used for the purpose of underwriting and determining eligibility for coverage.
3. This information shall also be used by QualChoice in investigating and adjudicating claims for benefits.
4. I understand that in the course of their business operations, QualChoice may disclose this information to others as required or permitted by law and as set out in the QualChoice ***Notice of Privacy Practices***.
5. I understand that information provided under this authorization if re-disclosed will no longer be protected. However, QualChoice and its associates are protected by federal and state privacy laws and regulations.
6. I specifically authorize QualChoice to release necessary information obtained by QualChoice about me to my broker/agent.
7. This authorization permits release of information related to substance use or abuse, but does not provide for the disclosure of psychotherapy notes as defined in 45 CFR § 164.501.
8. I acknowledge that signing this authorization is a condition of my enrollment for health coverage by QualChoice.
9. I understand that I may terminate this authorization by sending a written revocation to QualChoice, ATTN: MEDIQ65®, P.O. Box 25626, Little Rock, AR 72221-5626. However, if I revoke this authorization before I am enrolled in the MediQ65 policy, my application for coverage will be denied.
10. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims.
11. A photocopy of this authorization is as valid as the original.
12. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signature in Global and National Commerce Act 15 USC §§ 7001 et seq., the Arkansas Electronic Records and Signature Act A.C.A §§25-31-101 et seq. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i)
13. QualChoice may release any information obtained by it about me to MIB or any member company for purposes described in QualChoice's *Notice of Privacy Practices.*

PRINTED NAME OF APPLICANT	
SIGNATURE OF APPLICANT	DATE SIGNED (MM/DD/YYYY)

SECTION XI. PAYMENT AUTHORIZATION FORM

Use this form to select the type of payment method you want QualChoice to apply when billing your MediQ65® premium. Your application cannot be processed without this form being signed and returned.

Check (✓) one of the 3 payment methods below.

☐ **Bank Draft (Monthly).** I authorize QualChoice and the Bank/Financial Institution indicated below, to debit my MediQ65® premium from the account indicated below. This authority is to remain in full force and effect until my Bank has received written notification from me of the Bank Draft termination in such time and such manner as to afford the Bank a reasonable opportunity to act on it, or until the Bank has sent me ten (10) days' written notice of the Bank's termination of this agreement. I understand that by revoking the Bank Draft after I have agreed to it, I will also be terminating my MediQ65® coverage, UNLESS QualChoice has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the Bank Draft withdrawal date. I understand that if my bank rejects a draft due to insufficient funds in my account, QualChoice may charge me a fee of up to $20.00. In order to use Monthly Bank Draft as my payment method, I understand that I must submit this form to QualChoice and staple a blank check marked VOID in the top left-hand corner of this form. My first month's premium will be drafted upon initial acceptance of coverage. For all other premiums I may select one of two bank draft dates.

I understand and agree that my first month's premium will be drafted upon initial acceptance of coverage.

PLEASE CHECK ONE: For all other bank drafts I have checked (✓) below the preferred date. **Example**: Premiums due in January coverage month can be drafted on the 24th of December or the 5th of January.

☐ **24th of the month preceding the coverage month** -or- ☐ **5th of the coverage month**

Name Of Bank Or Financial Institution	Account Type (Check One) ☐ Checking ☐ Savings
Bank Account Number	9 Digit Bank Routing No.
Account Holder Name	Account Holder Address (Street, City, State, Zip)
Account Holder Signature	Date Signed (MM/DD/YYYY)

☐ **Monthly Billing ($2.00 monthly service fee applies).** Your monthly invoice will be mailed to your Billing Address as listed in Section I.

☐ **Quarterly Billing.** I authorize QualChoice to bill my MediQ65® premium on a quarterly basis. This type of billing arrangement is to remain in full force and effect until QualChoice receives written notice of my desire to change my billing arrangement. I must provide QualChoice notice to change my billing arrangement twenty (20) days prior to when my next premium payment is due. In order to use quarterly billing as my payment method, I understand that I must submit this form to QualChoice.

By signing this PAYMENT AUTHORIZATION FORM, I agree to all terms and conditions expressed in the payment method I have chosen above. I understand that not properly following what has been authorized on this form may cause my MediQ65® policy to be terminated at QualChoice's discretion.		
Printed Name of Applicant	**Signature of Applicant**	**Date Signed** (MM/DD/YYYY)

DISCLAIMER

MediQ65® Medicare Supplement plans are not connected with or endorsed by the U.S. Government or the Federal Medicare program.

FAIR CREDIT REPORTING ACT NOTICE

Notice to Proposed Insured

Please keep for your records.

In connection with your application for insurance an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to:

QualChoice MediQ65®
Underwriting Division
PO Box 25626
Little Rock, AR 72221-5626

Quick Checklist

Complete, sign and return the following forms in the enclosed postage-paid return envelope.

- ☐ **Application for Coverage**
- ☐ **Important Information for Applicant Form**
- ☐ **Authorization to Disclose PHI Form**
- ☐ **Payment Authorization form**
- ☐ **Attach check marked VOID if selecting Monthly Bank Draft**

FOR MORE INFORMATION ABOUT MEDICARE AND MEDIGAP

MediQ65 Medicare Supplement Plan — Weekdays 8 a.m. to 5 p.m. Central Time

Toll Free 1.855.MEDIQ65 (1.855.633.4765)
www.mediq65.com

Senior Health Insurance Information Program (SHIIP – State of Arkansas) provides free one-on-one counseling, education, and information to individuals with Medicare of all ages.

Toll Free 1.800.224.6330 or 501.371.2782
www.insurance.arkansas.gov

Medicare — 24 hours a day, 7 days a week

Toll Free 1.800.633.4227 (1.800.MEDICARE) • TTY/TDD users call 1.877.486.2048
Choosing A Medigap Policy: A Guide to Health Insurance for People with Medicare available at www.medicare.gov/publications

Application for Coverage

MediQ65® Medicare Supplement Insurance

Thank you for your interest in the QualChoice MediQ65® for your Medicare Supplement insurance coverage. You must be age 65, a resident of the State of Arkansas, and have both Medicare Part A and Medicare Part B to apply for MediQ65® coverage.

Please read the following information carefully to assure prompt processing of your application. A MediQ65® Application is also available at **www.mediq65.com.**

1. Complete this form yourself or with the help of an agent/broker authorized to sell QualChoice MediQ65® policies.
2. Answer each required question completely using dark blue or black ink. No pencil please.
3. Do not use liquid paper, correction tape or "white out" to correct any mistakes. If you make a mistake, mark through the incorrect information, initial it and then provide the correct information.
4. Complete all required sections to avoid delays in processing.
5. Sign and date the application as well as any attached sheets.
6. Keep a photocopy of this completed application and any attachments for your records.
7. Submit a voided blank check with the application if you want Monthly Bank Draft as your payment method. If electing monthly billing as your payment option, **DO NOT** send money with this application. You will be billed later.
8. Return this entire application and any attachments in the postage-paid return envelope provided. If certain sections do not apply to you, indicate so on the application.

NOTE:

- This application is a legal document, which will become part of your contract if you are approved for coverage. It is very important that you provide all requested information and that it is accurate and legible.
- The information provided here will be used and disclosed only as permitted by our *Notice of Privacy Practices* which can be viewed at **www.mediq65.com**.
- In answering the questions in this application, do not include any medical history or information related to genetic testing, services or counseling. Also, do not include any information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.

Policy Effective Dates

The policy effective date will be the 1st of the month after your application is approved and processed. Effective date of coverage cannot be:

- Prior to your Medicare Part A and Part B effective dates.
- Prior to your termination from a Medicare Advantage plan.
- Prior to your application submission date.

Question or Need Assistance?
Contact a MediQ65® Sales Manager
501.228.7111 or 855.633.4765 (855.MEDIQ65)
Monday-Friday 8 a.m. to 5 p.m.

SECTION I. WHO IS APPLYING

First Name	MI	Last Name	Gender	Date of Birth	Social Security Number

Primary Phone Number ( )	Secondary Phone Number ( )	Best Time to Call AM PM

Mailing Address	City	State **AR**	Zip Code	County
Billing Address (only if different from mailing address)	City	State **AR**	Zip Code	
Residential Address (only if different from mailing address)	City	State **AR**	Zip Code	

IMPORTANT DECISION:

I want to do my part for the environment and reduce waste. By checking **YES** below**,** I agree that QualChoice can deliver all documents, notices and any other communications with respect to my MediQ65® coverage electronically to my email address below. This includes, but is not limited to, my Insurance Certificate of Coverage, all explanation of benefits describing how my claims have been adjudicated, billing invoices, renewal notices, and any other communications. I understand I can change my mind at any time and revoke my decision to have these documents and communications sent to me electronically simply by contacting QualChoice at 1.855.MEDIQ65 (1.855.633.4765). I also understand that I can ask QualChoice at any time to provide me with any of these documents in paper form by regular mail. I agree to contact QualChoice if my email address changes so that these important documents, notices and communications will come to my new email address.

☐**Yes** ☐ **No** **E-Mail Address**_____

SECTION II. ELIGIBILITY INFORMATION

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans.

Please answer all questions and include a copy of the notice from your prior insurer with this application.

Please check *(✓)* **YES** or **NO**

SECTION II. ELIGIBILITY INFORMATION

1. Did you turn age 65 in the last 6 months? ☐ YES ☐ NO
   a. Did you enroll in Medicare Part B in the last 6 months? ☐ YES ☐ NO
   b. If **YES**, what is the effective date? (MM/DD/YYYY) _____

2. Are you covered for medical assistance through the state Medicaid program?
   NOTE TO APPLICANT: If you are participating in a Spend-Down Program and have not met your Share of Cost, please respond **NO** to this question ☐ YES ☐ NO
   a. If **YES**, will Medicaid pay your premiums for this Medicare supplement policy? ☐ YES ☐ NO
   b. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium? ☐ YES ☐ NO

3. If you had coverage from any Medicare plan, other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO, PPO or PFFS), fill in your **START DATE** and **END DATE** below. If you are still covered under this plan, leave the **END DATE** blank.

   START DATE (MM/DD/YYYY)_____ **END DATE (MM/DD/YYYY)** _____

4. If you are still covered under the other Medicare plan. Do you intend to replace your current coverage with this new Medicare supplement policy? ☐ YES ☐ NO
   a. Was this your first time in this type of Medicare plan? ☐ YES ☐ NO
   b. Did you drop a Medicare supplement policy to enroll in the Medicare plan? ☐ YES ☐ NO
   c. Did you move out of the service area of your Medicare Advantage plan? ☐ YES ☐ NO
   d. Did your Medicare Advantage plan terminate its contract with CMS, cease to provide all services, violate its contract or otherwise notify you that you were losing coverage and eligible for guarantee issue into a Medigap policy? ☐ YES ☐ NO

5. Do you have another Medicare supplement policy in force? ☐ YES ☐ NO
   a. If **YES**, what is the name of the company? _____ Name of Plan? _____
   b. If **YES**, do you plan to replace your current Medicare supplement policy with this MediQ65 policy? (Please contact the MediQ65® Sales Manager to request the ***Notice of Replacement Questionnaire***.) ☐ YES ☐ NO

6. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan?) ☐ YES ☐ NO
   a. If **YES**, please list name of carrier. _____
   b. If **YES**, What are your dates of coverage under the other policy? If you are still covered under the other policy, leave **END DATE** blank.

   START DATE (MM/DD/YYYY) _____ **END DATE (MM/DD/YYYY)** _____

SECTION III. YOUR MEDICARE INSURANCE INFORMATION

You must have both Medicare Hospital (Part A) and Medical (Part B) coverage to apply for MediQ65®

Please FILL IN THE BLANKS below to match your red, white and blue Medicare Health Insurance card.

Medicare Number	Hospital (**Part A**) Effective Date MM/DD/YYYY)	Medical (**Part B**) Effective Date (MM/DD/YYYY)

SECTION IV. CHOOSE YOUR PLAN.

Check (✓) only one.

Please enroll me in the following MediQ65® Plan:	MediQ65® Plan A ☐	MediQ65® Plan F ☐	MediQ65® Plan G ☐	MediQ65® Plan N ☐

Do you currently have QualChoice health coverage? ☐ No ☐ Yes

If **YES**, please write your QualChoice ID No. below

ID No. _____

IMPORTANT INFORMATION!

Please read carefully before continuing the application process.

Open Enrollment Period

Under the OPEN ENROLLMENT PERIOD health questions are not required to be answered. You are **NOT** required to complete Sections V-VIII if you are applying during the Medicare Supplement Open Enrollment Period. Please continue your application process at Section IX.

If You Are NOT in the Open Enrollment Period

Please answer ALL of the following health questions. Acceptance of your application is subject to your enrollment in Medicare Hospital (Part A) and Medical (Part B) coverage, Arkansas residency and our review of your answers to the medical questions. Your application cannot be processed unless all questions are answered.

SECTION V. PRIMARY CARE PHYSICIAN INFORMATION

Complete Name and Address of Physician	Date of Last Visit	Reason for Visit

SECTION VI. MEDICAL QUESTIONS

Please answer all questions if this section applies to you.

Please check (✓) either **YES** or **NO**.

1. What is your height? _____ft _____in

2. What is your weight? _____lbs

3. Are you Medicare disabled? ☐ YES ☐ NO
   If **YES**, please indicate disability condition(s) below.

4. Have you ever been declined or rejected for the issuance of life, accident, health or long term care insurance? ☐ YES ☐ NO
   a. If **YES,** Name of Carrier _____Year_____
      Reason_____

5. Have you used any form of tobacco within the past 12 months? ☐ YES ☐ NO
   a. If **YES**, Type of Tobacco _____Amount of Use _____

6. In the **last 5 years** have you:
   a. Had home health care services for any reason? ☐ YES ☐ NO
      If **YES,** please explain:

   b. Required the assistance of any other individual for performances of any activities of daily living? ☐ YES ☐ NO

      If **YES**, please check all that apply:
      ☐ Bathing ☐ Dressing ☐ Transferring ☐ Eating ☐ Toileting ☐ Continence

   c. Used any addictive or non-addictive drug or substance except as provided by a physician? ☐ YES ☐ NO

      If **YES**, please explain:

   d. Used alcohol in amounts greater than 3 drinks per day? ☐ YES ☐ NO

SECTION VI. MEDICAL QUESTIONS

Please answer all questions if this section applies to you.

7. Have you:

a. Ever had inpatient or outpatient cardiac surgery or other cardiac procedures? ☐ YES ☐ NO

b. Ever been diagnosed and/or treated for cancer (other than skin cancer)? ☐ YES ☐ NO

c. Been hospitalized since turning age 65? ☐ YES ☐ NO

If **YES**, how many total days were you in the hospital? No. of Total Days _____

SECTION VI. MEDICAL QUESTIONS (cont'd)

In answering the questions in this application, do not include any medical history or information related to genetic testing, services or counseling. Also, do not include any information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.

Give full details in Section VII: ADDITIONAL MEDICAL INFORMATION for each question checked below. Each question must have at least one box checked – if none of the the conditions apply; you must check 'None of the Above' on each question.

In the past three (3) years have you been treated for or been told you had:

8. **BRAIN OR NERVOUS SYSTEM DISORDERS**

- ☐ Alzheimer's disease or senile dementia
- ☐ Amyotrophic lateral sclerosis (ALS - Lou Gehrig's disease)
- ☐ Convulsion, epilepsy or seizures
- ☐ Meningitis
- ☐ Multiple sclerosis, muscular dystrophy or myasthenia gravis
- ☐ Neuritis or Polyneuritis
- ☐ Paralysis or palsy
- ☐ Parkinson's disease
- ☐ Vertigo, fainting or dizziness
- ☐ Any other disorder of the brain or nervous system
- ☐ None of the above

9. RESPIRATORY

- ☐ Chronic obstructive pulmonary disease or asthma
- ☐ Obstructive or reactive airway disorder
- ☐ Home oxygen therapy
- ☐ Any other disorder of the lungs, bronchial tubes or respiratory system
- ☐ None of the above

SECTION VI. MEDICAL QUESTIONS (cont'd)

In answering the questions in this application, do not include any medical history or information related to genetic testing, services or counseling. Also, do not include any information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.

Give full details in Section VII: ADDITIONAL MEDICAL INFORMATION for each question checked below. Each question must have at least one box checked – if none of the the conditions apply; you must check 'None of the Above' on each question.

In the past three (3) years have you been treated for or been told you had:

- ☐ Cirrhosis, hepatitis
- ☐ Crohn's disease or ulcerative colitis
- ☐ Diverticulitis
- ☐ Gastric bypass surgery or other weight loss procedure
- ☐ Gastric or duodenal ulcer
- ☐ Irritable bowel syndrome
- ☐ Gastric esophageal reflux disorder (GERD)
- ☐ Pancreatitis
- ☐ Any other disorder of the stomach, intestines, liver, gallbladder or rectum
- ☐ None of the above

11. EARS/EYES/NOSE/THROAT

- ☐ Cataracts or glaucoma
- ☐ Any other disorder of the eyes, ears, nose, throat or esophagus
- ☐ None of the above

12. GLANDULAR

- ☐ Adrenal disorders
- ☐ Diabetes, abnormal glucose
- ☐ Any other disorder of the pancreas, thyroid, pituitary, adrenal or other glands
- ☐ None of the above

SECTION VI. MEDICAL QUESTIONS (cont'd)

In answering the questions in this application, do not include any medical history or information related to genetic testing, services or counseling. Also, do not include any information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.

Give full details in Section VII: ADDITIONAL MEDICAL INFORMATION for each question checked below. Each question must have at least one box checked – if none of the the conditions apply; you must check 'None of the Above' on each question.

In the past three (3) years have you been treated for or been told you had:

13. CIRCULATORY

- ☐ Angina, heart attack, myocardial infarction, arteriosclerosis, coronary artery disease, shunt placement and/or angioplasty
- ☐ Cerebrovascular accident (stroke) including transient ischemic attack (TIA)
- ☐ Chest pain, shortness of breath, heart murmur palpitation of the heart, rheumatic fever
- ☐ Heart bypass surgery, pacemaker implant
- ☐ Heart surgery
- ☐ High blood pressure
- ☐ Hemophilia
- ☐ Any other condition of the heart, blood, blood vessels or circulatory system
- ☐ None of the above

14. CANCER, LYMPHATIC SYSTEM, BLOOD, OR SKIN DISORDERS

- ☐ Anemia
- ☐ Cancer
- ☐ Hodgkin's disease
- ☐ Leukemia
- ☐ Melanoma, neoplasm or tumor
- ☐ Any other disorder of the lymphatic system
- ☐ Any other disorder of the skin
- ☐ None of the above

15. MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Chronic fatigue
- ☐ Connective tissue disorder
- ☐ Fracture(s) or broken bone(s) — Exposed bone? ☐ YES ☐ NO
- ☐ Fibromyalgia
- ☐ Lupus, systemic
- ☐ Any other disorder of the muscles, bones or joints
- ☐ None of the above

SECTION VI. MEDICAL QUESTIONS (cont'd)

In answering the questions in this application, do not include any medical history or information related to genetic testing, services or counseling. Also, do not include any information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.

Give full details in Section VII: ADDITIONAL MEDICAL INFORMATION for each question checked below. Each question must have at least one box checked – if none of the the conditions apply; you must check 'None of the Above' on each question.

In the past three (3) years have you been treated for or been told you had:

16. KIDNEY, URINARY, REPRODUCTIVE

- ☐ Abnormal pap smear
- ☐ Bladder or renal stones
- ☐ Dialysis
- ☐ Nephritis
- ☐ Nephrotic syndrome, renal disease or failure
- ☐ Sexually transmitted disease
- ☐ Sugar, blood or protein in urine
- ☐ Any other disorder of the reproductive organs, including prostate, ovaries or breasts
- ☐ None of the above

17. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE

- ☐ Anxiety, depression, emotional problems or nervous disorder
- ☐ Drug overdose
- ☐ Eating disorder
- ☐ Psychiatric treatment
- ☐ Any other mental, emotional disorder or situation
- ☐ None of the above

18. OTHER

- ☐ Current patient in a hospital or nursing home
- ☐ Sarcoidosis
- ☐ Any other implant(s), prosthetic device(s) internal fixation device(s) or retained hardware (i.e.. Pins, wires, screws, shunts, stents)
- ☐ Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder, or HIV
- ☐ Transplant recipient
- ☐ Surgery, procedure, or test advised by physician but not completed
- ☐ Unexplained or unintentional weight loss of 10 pounds or more
- ☐ Any injury deformity, incapacitation, disease or condition not listed elsewhere
- ☐ None of the above

SECTION VII. ADDITIONAL MEDICAL INFORMATION

1. Give full details to conditions checked in **Section VI, Questions 8-18**.
2. Include all treatments provided or planned that apply in the "Type of Treatment" section. Example treatments are:
   - Surgery Hospitalization
   - Emergency room visit
   - Chiropractic treatments
   - Nursing Home confinement
   - Doctor visits
   - Rehabilitation therapy (speech, physical, occupations)
3. Please ensure you include all the treatments that apply.
4. Indicate the name(s) that would have been given at the time of the physician visit-e.g. a maiden name.

NAME: _____

Question Number	Condition/Illness -and- Type of Treatment	Date of first Diagnosis		Date of Most Recent Visit		Total # of Visits	Degree of Recovery			Complete Name -and- Address of Physician
		MO	YR	MO	YR		None	Partial	Full	
15.	**Condition/Illness:** Arthritis **Type of Treatment:** Doctor Visit	8/10 **Mo Year**		6/12 Mo Year		8		X		Dr. XYZ 123 Any Street Any Place, AR
	Condition/Illness: Type of Treatment:	___/____ Mo Year		___/____ Mo Year						
	Condition/Illness: Type of Treatment:	___/____ Mo Year		___/____ Mo Year						
	Condition/Illness: Type of Treatment:	___/____ Mo Year		___/____ Mo Year						
	Condition/Illness: Type of Treatment:	___/____ Mo Year		___/____ Mo Year						
	Condition/Illness: Type of Treatment:	___/____ Mo Year		___/____ Mo Year						

SECTION VIII. PRESCRIPTION QUESTIONNAIRE

1. Are you currently taking any prescription medication, or have you taken prescription medication in the **last three (3) years**? ☐ YES ☐ NO

SECTION VII. ADDITIONAL MEDICAL INFORMATION

2. If you answered **YES**, please provide full details below. A print out from the pharmacy in **not** acceptable.

Name of Medication	**Dosage**	**Specific Condition or Illness**	Start Date (MM/YYYY)	Stop Date (MM/YYYY)	**Degree of Recovery**			**Complete Name - and- Address of Physician**
					None	Partial	Full	
Tylenol	1000 mg	Osteoarthritis	06/2008	Current	X			Dr. XYZ 123 Any Street Any Place, AR

SECTION IX: IMPORTANT INFORMATION FOR APPLICANT FORM

Carefully read and sign. Your application cannot be processed without this form being signed and returned.

Send no money with this application. You will be billed.

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. If, after purchasing this policy you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

IN SIGNING BELOW, I REPRESENT AND ACKNOWLEDGE

1. That I should not cancel any coverage I currently have until I am notified of QualChoice's decision.
2. An agent/broker involved in this insurance transaction may receive compensation from QualChoice for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent/broker.
3. If my application is accepted relying on my representations on this document, any coverage which may be issued to me shall be invalid if based on false information.
4. I agree any provider of medical services or supplies is authorized and directed to furnish QualChoice all records or copies thereof, relating to such services or supplies.
5. I authorize and release to QualChoice, Title XVIII Medicare claims information needed to coordinate benefits with this policy at any time I am eligible for Medicare benefits.
6. QualChoice may phone me for additional information that may help with the timely processing of my application.

IN SIGNING BELOW, I REPRESENT AND ACKNOWLEDGE

7. That the statements and answers given in this application and any signed and dated addenda to this application (both front and back) are true, complete and correctly recorded.
8. I have read and understand the **Important Information for Applicant** (Section IX).
9. I ACKNOWLEDGE my understanding that consistent with the requirements of the **Genetic Information Nondiscrimination Act of 2008**, QualChoice does not use genetic information for underwriting purposes or any other purpose prohibited by applicable law. I also acknowledge that QualChoice has requested that in answering the questions in the attached application I do not include any family medical history or information related to genetic testing, genetic services or genetic counseling. Also, QualChoice has requested that I do not include information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information. I further acknowledge that QualChoice has directed me to omit or remove from the attached application any genetic information.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

- I, the applicant, certify that I signed this application in the state of Arkansas.
- I, the applicant or my authorized representative, acknowledge receipt of the following:
  - ☐ ***Choosing A Medigap Policy: A Guide to Health Insurance for People with Medicare*** (available at www.medicare.gov/publications) and ***Outline of Medicare Supplement Coverage*** from QualChoice.

SIGNATURE OF APPLICANT	**DATE SIGNED** (MM/DD/YYYY)

FOR AGENT / BROKER ONLY

If application is being made through an agent/broker, he/she must complete the following:

I have read and understand the MediQ65® ***Application for Coverage***. I additionally certify that the applicant has received the *Choosing A Medigap Policy: A Guide to Health Insurance for People with Medicare* and the *Outline of Medicare Supplement Coverage* for the policy applied for and that the applicant has Medicare Parts A and B. The policy applied for will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage.

Before this form can be processed, the agent/broker's current health and life license must be on file with QualChoice. In addition, the agent/broker must be appointed with QualChoice.

AGENCY FEDERAL TAX ID # (IF APPLICABLE)	**AGENT/BROKER LICENSE #**	**PHONE NUMBER**
AGENT/BROKER PRINTED NAME	**AGENT/BROKER SIGNATURE**	**DATE SIGNED** (MM/DD/YYYY)

List below all health insurance policies you have issued to this applicant that are still in force and any other health insurance issued in the past five (5) years that are no longer in force and submit with this application as required.

NAME OF POLICY	NAME OF INSURANCE COMPANY	POLICY DATE (MM/DD/YYYY)	
		To	From

SECTION X: AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) FORM

Your application cannot be processed without this form being signed and returned.

1. I authorize any medical professional, medical care institution, other provider of health care services or supplies, the Medical Information Bureau (MIB), reinsurer, health plan, prior insurance carrier, consumer reporting agency, other third party medical and/or pharmaceutical databases or other organization, institution or person, that has any records on me or my health to provide QualChoice, any third party retained by QualChoice, or its reinsurers, information with respect to any physical or mental condition, treatment or any non-medical information on me.
2. I understand that information obtained as a result of this authorization will be used for the purpose of underwriting and determining eligibility for coverage.
3. This information shall also be used by QualChoice in investigating and adjudicating claims for benefits.
4. I understand that in the course of their business operations, QualChoice may disclose this information to others as required or permitted by law and as set out in the QualChoice ***Notice of Privacy Practices***.
5. I understand that information provided under this authorization if re-disclosed will no longer be protected. However, QualChoice and its associates are protected by federal and state privacy laws and regulations.
6. I specifically authorize QualChoice to release necessary information obtained by QualChoice about me to my broker/agent.
7. This authorization permits release of information related to substance use or abuse, but does not provide for the disclosure of psychotherapy notes as defined in 45 CFR § 164.501.
8. I acknowledge that signing this authorization is a condition of my enrollment for health coverage by QualChoice.
9. I understand that I may terminate this authorization by sending a written revocation to QualChoice, ATTN: MEDIQ65®, P.O. Box 25626, Little Rock, AR 72221-5626. However, if I revoke this authorization before I am enrolled in the MediQ65 policy, my application for coverage will be denied.
10. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims.
11. A photocopy of this authorization is as valid as the original.
12. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signature in Global and National Commerce Act 15 USC §§ 7001 et seq., the Arkansas Electronic Records and Signature Act A.C.A §§25-31-101 et seq. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i)
13. QualChoice may release any information obtained by it about me to MIB or any member company for purposes described in QualChoice's *Notice of Privacy Practices.*

PRINTED NAME OF APPLICANT	
SIGNATURE OF APPLICANT	DATE SIGNED (MM/DD/YYYY)

SECTION XI. PAYMENT AUTHORIZATION FORM

Use this form to select the type of payment method you want QualChoice to apply when billing your MediQ65® premium. Your application cannot be processed without this form being signed and returned.

Check (✓) one of the 3 payment methods below.

☐ **Bank Draft (Monthly).** I authorize QualChoice and the Bank/Financial Institution indicated below, to debit my MediQ65® premium from the account indicated below. This authority is to remain in full force and effect until my Bank has received written notification from me of the Bank Draft termination in such time and such manner as to afford the Bank a reasonable opportunity to act on it, or until the Bank has sent me ten (10) days' written notice of the Bank's termination of this agreement. I understand that by revoking the Bank Draft after I have agreed to it, I will also be terminating my MediQ65® coverage, UNLESS QualChoice has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the Bank Draft withdrawal date. I understand that if my bank rejects a draft due to insufficient funds in my account, QualChoice may charge me a fee of up to $20.00. In order to use Monthly Bank Draft as my payment method, I understand that I must submit this form to QualChoice and staple a blank check marked VOID in the top left-hand corner of this form. My first month's premium will be drafted upon initial acceptance of coverage. For all other premiums I may select one of two bank draft dates.

I understand and agree that my first month's premium will be drafted upon initial acceptance of coverage.

PLEASE CHECK ONE: For all other bank drafts I have checked (✓) below the preferred date. **Example**: Premiums due in January coverage month can be drafted on the 24th of December or the 5th of January.

☐ **24th of the month preceding the coverage month** -or- ☐ **5th of the coverage month**

Name Of Bank Or Financial Institution	Account Type (Check One) ☐ Checking ☐ Savings
Bank Account Number	9 Digit Bank Routing No.
Account Holder Name	Account Holder Address (Street, City, State, Zip)
Account Holder Signature	Date Signed (MM/DD/YYYY)

☐ **Monthly Billing ($2.00 monthly service fee applies).** Your monthly invoice will be mailed to your Billing Address as listed in Section I.

☐ **Quarterly Billing.** I authorize QualChoice to bill my MediQ65® premium on a quarterly basis. This type of billing arrangement is to remain in full force and effect until QualChoice receives written notice of my desire to change my billing arrangement. I must provide QualChoice notice to change my billing arrangement twenty (20) days prior to when my next premium payment is due. In order to use quarterly billing as my payment method, I understand that I must submit this form to QualChoice.

By signing this PAYMENT AUTHORIZATION FORM, I agree to all terms and conditions expressed in the payment method I have chosen above. I understand that not properly following what has been authorized on this form may cause my MediQ65® policy to be terminated at QualChoice's discretion.		
Printed Name of Applicant	**Signature of Applicant**	**Date Signed (MM/DD/YYYY)**

DISCLAIMER

MediQ65® Medicare Supplement plans are not connected with or endorsed by the U.S. Government or the Federal Medicare program.

FAIR CREDIT REPORTING ACT NOTICE

Notice to Proposed Insured

Please keep for your records.

In connection with your application for insurance an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to:

QualChoice MediQ65®
Underwriting Division
PO Box 25626
Little Rock, AR 72221-5626

Quick Checklist
Complete, sign and return the following forms in the enclosed postage-paid return envelope.
☐ **Application for Coverage**
☐ **Important Information for Applicant Form**
☐ **Authorization to Disclose PHI Form**
☐ **Payment Authorization form**
☐ **Attach check marked VOID if selecting Monthly Bank Draft**

FOR MORE INFORMATION ABOUT MEDICARE AND MEDIGAP
MediQ65 Medicare Supplement Plan — Weekdays 8 a.m. to 5 p.m. Central Time
Toll Free 1.855.MEDIQ65 (1.855.633.4765) www.mediq65.com
Senior Health Insurance Information Program (SHIIP – State of Arkansas) provides free one-on-one counseling, education, and information to individuals with Medicare of all ages.
Toll Free 1.800.224.6330 or 501.371.2782 www.insurance.arkansas.gov
Medicare — 24 hours a day, 7 days a week
Toll Free 1.800.633.4227 (1.800.MEDICARE) • TTY/TDD users call 1.877.486.2048 ***Choosing A Medigap Policy: A Guide to Health Insurance for People with Medicare*** available at www.medicare.gov/publications

SERFF Tracking #:	*QUAC-128648098*	***State Tracking #:***	***Company Tracking #:***

State:	*Arkansas*	***Filing Company:***	*QualChoice Life and Health Insurance Company, Inc.*
TOI/Sub-TOI:	*MS05I Individual Medicare Supplement - Standard Plans/MS05I.015 Multi-Plan*		
Product Name:	*MediQ65*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved-Closed	08/24/2012
Comments:			
Attachment(s):			
Flesch Certification Aug 2012.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Application	Approved-Closed	08/24/2012
Comments:			
Attachment(s):			
MediQ65 Application Revised 8 16 12.pdf			

		Item Status:	**Status Date:**
Bypassed - Item:	Health - Actuarial Justification		
Bypass Reason:	Not applicable to this filing.		
Comments:			

		Item Status:	**Status Date:**
Bypassed - Item:	Outline of Coverage		
Bypass Reason:	Not applicable to this filing.		
Comments:			

QualChoice®

QualChoice Life and Health Insurance Company, Inc.
QCA Health Plan, Inc.
QualChoice Holdings, Inc.

VIA SERFF

August 17, 2012

Ms. Stephanie Fowler
Arkansas Department of Insurance
Life and Health Division
1200 West Third Street
Little Rock, AR 72201-1904

RE: QualChoice Life and Health Insurance Company, Inc. Medicare Supplement Modified Application Filing

Dear Ms. Fowler:

This certifies that the following Medigap application does not meet the minimum score of forty (40) on the Flesch reading ease test as specified in Ark. Stat. Ann. §23-80-206:

MediQ65 Application For Coverage (Form No. 1110MK007_02 (7/2012))

Although the score is lower than the minimum required, it should be approved in accordance with Ark. Stat. Ann. §23-80-207 and warranted due to the nature of the policy form and necessary inclusion of medical terminology and language drafted to conform to state and federal law.

Please feel free to contact me at any time should you need additional information or have any questions or comments.

Sincerely yours,

James W. Couch, J.D.
Vice President of Compliance
jim.couch@qualchoice.com
(501) 219-5118

Application for Coverage

MediQ65® Medicare Supplement Insurance

Thank you for your interest in the QualChoice MediQ65® for your Medicare Supplement insurance coverage. You must be age 65, a resident of the State of Arkansas, and have both Medicare Part A and Medicare Part B to apply for MediQ65® coverage.

Please read the following information carefully to assure prompt processing of your application. A MediQ65® Application is also available at **www.mediq65.com.**

1. Complete this form yourself or with the help of an agent/broker authorized to sell QualChoice MediQ65® policies.
2. Answer each required question completely using dark blue or black ink. No pencil please.
3. Do not use liquid paper, correction tape or "white out" to correct any mistakes. If you make a mistake, mark through the incorrect information, initial it and then provide the correct information.
4. Complete all required sections to avoid delays in processing.
5. Sign and date the application as well as any attached sheets.
6. Keep a photocopy of this completed application and any attachments for your records.
7. Submit a voided blank check with the application if you want Monthly Bank Draft as your payment method. If electing monthly billing as your payment option, **DO NOT** send money with this application. You will be billed later.
8. Return this entire application and any attachments in the postage-paid return envelope provided. If certain sections do not apply to you, indicate so on the application.

NOTE:

- This application is a legal document, which will become part of your contract if you are approved for coverage. It is very important that you provide all requested information and that it is accurate and legible.
- The information provided here will be used and disclosed only as permitted by our *Notice of Privacy Practices* which can be viewed at **www.mediq65.com**.
- In answering the questions in this application, do no include any medical history or information related to genetic testing, services or counseling. Also, do not include any information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.

Policy Effective Dates

The policy effective date will be the 1st of the month after your application is approved and processed. Effective date of coverage cannot be:

- Prior to your Medicare Part A and Part B effective dates.
- Prior to your termination from a Medicare Advantage plan.
- Prior to your application submission date.

Question or Need Assistance?
Contact a MediQ65® Sales Manager
501.228.7111 or 855.633.4765 (855.MEDIQ65)
Monday-Friday 8 a.m. to 5 p.m.

SECTION I. WHO IS APPLYING

First Name	MI	Last Name	Gender	Date of Birth	Social Security Number

Primary Phone Number ( )	Secondary Phone Number ( )	Best Time to Call AM PM

Mailing Address	City	State **AR**	Zip Code	County
Billing Address (only if different from mailing address)	City	State **AR**	Zip Code	
Residential Address (only if different from mailing address)	City	State **AR**	Zip Code	

IMPORTANT DECISION:

I want to do my part for the environment and reduce waste. By checking **YES** below**,** I agree that QualChoice can deliver all documents, notices and any other communications with respect to my MediQ65® coverage electronically to my email address below. This includes, but is not limited to, my Insurance Certificate of Coverage, all explanation of benefits describing how my claims have been adjudicated, billing invoices, renewal notices, and any other communications. I understand I can change my mind at any time and revoke my decision to have these documents and communications sent to me electronically simply by contacting QualChoice at 1.855.MEDIQ65 (1.855.633.4765). I also understand that I can ask QualChoice at any time to provide me with any of these documents in paper form by regular mail. I agree to contact QualChoice if my email address changes so that these important documents, notices and communications will come to my new email address.

☐ **Yes** ☐ **No** **E-Mail Address**_____

SECTION II. ELIGIBILITY INFORMATION

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans.

Please answer all questions and include a copy of the notice from your prior insurer with this application.

Please check *(✓)* **YES** or **NO**

SECTION II. ELIGIBILITY INFORMATION

1. Did you turn age 65 in the last 6 months? ☐ YES ☐ NO
   a. Did you enroll in Medicare Part B in the last 6 months? ☐ YES ☐ NO
   b. If **YES**, what is the effective date? (MM/DD/YYYY) _____

2. Are you covered for medical assistance through the state Medicaid program?
   NOTE TO APPLICANT: If you are participating in a Spend-Down Program and have not met your Share of Cost, please respond **NO** to this question ☐ YES ☐ NO
   a. If **YES**, will Medicaid pay your premiums for this Medicare supplement policy? ☐ YES ☐ NO
   b. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium? ☐ YES ☐ NO

3. If you had coverage from any Medicare plan, other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO, PPO or PFFS), fill in your **START DATE** and **END DATE** below. If you are still covered under this plan, leave the **END DATE** blank.

   START DATE (MM/DD/YYYY)_____ **END DATE (MM/DD/YYYY)** _____

4. If you are still covered under the other Medicare plan. Do you intend to replace your current coverage with this new Medicare supplement policy? ☐ YES ☐ NO
   a. Was this your first time in this type of Medicare plan? ☐ YES ☐ NO
   b. Did you drop a Medicare supplement policy to enroll in the Medicare plan? ☐ YES ☐ NO
   c. Did you move out of the service area of your Medicare Advantage plan? ☐ YES ☐ NO
   d. Did your Medicare Advantage plan terminate its contract with CMS, cease to provide all services, violate its contract or otherwise notify you that you were losing coverage and eligible for guarantee issue into a Medigap policy? ☐ YES ☐ NO

5. Do you have another Medicare supplement policy in force? ☐ YES ☐ NO
   a. If **YES**, what is the name of the company? _____ Name of Plan? _____
   b. If **YES**, do you plan to replace your current Medicare supplement policy with this MediQ65 policy? (Please contact the MediQ65® Sales Manager to request the ***Notice of Replacement Questionnaire***.) ☐ YES ☐ NO

6. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan?) ☐ YES ☐ NO
   a. If **YES**, please list name of carrier. _____
   b. If **YES**, What are your dates of coverage under the other policy? If you are still covered under the other policy, leave **END DATE** blank.

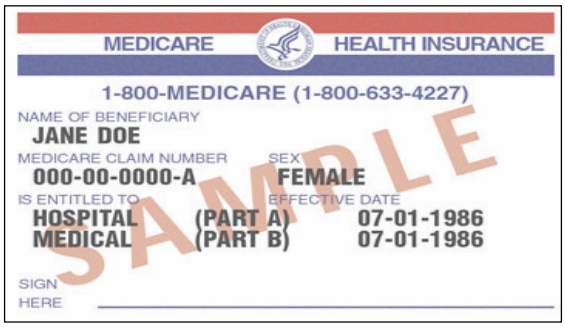
   START DATE (MM/DD/YYYY) _____ **END DATE (MM/DD/YYYY)** _____

SECTION III. YOUR MEDICARE INSURANCE INFORMATION

You must have both Medicare Hospital (Part A) and Medical (Part B) coverage to apply for MediQ65®

Please FILL IN THE BLANKS below to match your red, white and blue Medicare Health Insurance card.

Medicare Number	Hospital (**Part A**) Effective Date MM/DD/YYYY)	Medical (**Part B**) Effective Date (MM/DD/YYYY)



SECTION IV. CHOOSE YOUR PLAN.

Check (✓) only one.

Please enroll me in the following MediQ65® Plan:	MediQ65® Plan A ☐	MediQ65® Plan F ☐	MediQ65® Plan G ☐	MediQ65® Plan N ☐

Do you currently have QualChoice health coverage? ☐ No ☐ Yes

If **YES**, please write your QualChoice ID No. below

ID No. _____

IMPORTANT INFORMATION!

Please read carefully before continuing the application process.

Open Enrollment Period

Under the OPEN ENROLLMENT PERIOD health questions are not required to be answered. You are **NOT** required to complete Sections V-VIII if you are applying during the Medicare Supplement Open Enrollment Period. Please continue your application process at Section IX.

If You Are **NOT** in the Open Enrollment Period

Please answer ALL of the following health questions. Acceptance of your application is subject to your enrollment in Medicare Hospital (Part A) and Medical (Part B) coverage, Arkansas residency and our review of your answers to the medical questions. Your application cannot be processed unless all questions are answered.

SECTION V. PRIMARY CARE PHYSICIAN INFORMATION

Complete Name and Address of Physician	Date of Last Visit	Reason for Visit

SECTION VI. MEDICAL QUESTIONS

Please answer all questions if this section applies to you.

Please check (✓) either **YES** or **NO**.

1. What is your height? _____ft _____in

2. What is your weight? _____lbs

3. Are you Medicare disabled? ☐ YES ☐ NO
   If **YES**, please indicate disability condition(s) below.

4. Have you ever been declined or rejected for the issuance of life, accident, health or long term care insurance? ☐ YES ☐ NO
   a. If **YES,** Name of Carrier _____Year_____
      Reason_____

5. Have you used any form of tobacco within the past 12 months? ☐ YES ☐ NO
   a. If **YES**, Type of Tobacco _____Amount of Use _____

6. In the **last 5 years** have you:
   a. Had home health care services for any reason? ☐ YES ☐ NO
      If **YES,** please explain:

   b. Required the assistance of any other individual for performances of any activities of daily living? ☐ YES ☐ NO

      If **YES**, please check all that apply:
      ☐ Bathing ☐ Dressing ☐ Transferring ☐ Eating ☐ Toileting ☐ Continence

   c. Used any addictive or non-addictive drug or substance except as provided by a physician? ☐ YES ☐ NO

      If **YES**, please explain:

   d. Used alcohol in amounts greater than 3 drinks per day? ☐ YES ☐ NO

SECTION VI. MEDICAL QUESTIONS

Please answer all questions if this section applies to you.

7. Have you:

a. Ever had inpatient or outpatient cardiac surgery or other cardiac procedures? ☐ YES ☐ NO

b. Ever been diagnosed and/or treated for cancer (other than skin cancer)? ☐ YES ☐ NO

c. Been hospitalized since turning age 65? ☐ YES ☐ NO

If **YES**, how many total days were you in the hospital? No. of Total Days _____

SECTION VI. MEDICAL QUESTIONS (cont'd)

In answering the questions in this application, do no include any medical history or information related to genetic testing, services or counseling. Also, do not include any information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.

Give full details in Section VII: ADDITIONAL MEDICAL INFORMATION for each question checked below. Each question must have at least one box checked – if none of the the conditions apply; you must check 'None of the Above' on each question.

In the past three (3) years have you been treated for or been told you had:

8. **BRAIN OR NERVOUS SYSTEM DISORDERS**

- ☐ Alzheimer's disease or senile dementia
- ☐ Amyotrophic lateral sclerosis (ALS - Lou Gehrig's disease)
- ☐ Convulsion, epilepsy or seizures
- ☐ Meningitis
- ☐ Multiple sclerosis, muscular dystrophy or myasthenia gravis
- ☐ Neuritis or Polyneuritis
- ☐ Paralysis or palsy
- ☐ Parkinson's disease
- ☐ Vertigo, fainting or dizziness
- ☐ Any other disorder of the brain or nervous system
- ☐ None of the above

9. RESPIRATORY

- ☐ Chronic obstructive pulmonary disease or asthma
- ☐ Obstructive or reactive airway disorder
- ☐ Home oxygen therapy
- ☐ Any other disorder of the lungs, bronchial tubes or respiratory system
- ☐ None of the above

SECTION VI. MEDICAL QUESTIONS (cont'd)

In answering the questions in this application, do no include any medical history or information related to genetic testing, services or counseling. Also, do not include any information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.

Give full details in Section VII: ADDITIONAL MEDICAL INFORMATION for each question checked below. Each question must have at least one box checked – if none of the the conditions apply; you must check 'None of the Above' on each question.

In the past three (3) years have you been treated for or been told you had:

- ☐ Cirrhosis, hepatitis
- ☐ Crohn's disease or ulcerative colitis
- ☐ Diverticulitis
- ☐ Gastric bypass surgery or other weight loss procedure
- ☐ Gastric or duodenal ulcer
- ☐ Irritable bowel syndrome
- ☐ Gastric esophageal reflux disorder (GERD)
- ☐ Pancreatitis
- ☐ Any other disorder of the stomach, intestines, liver, gallbladder or rectum
- ☐ None of the above

11. EARS/EYES/NOSE/THROAT

- ☐ Cataracts or glaucoma
- ☐ Any other disorder of the eyes, ears, nose, throat or esophagus
- ☐ None of the above

12. GLANDULAR

- ☐ Adrenal disorders
- ☐ Diabetes, abnormal glucose
- ☐ Any other disorder of the pancreas, thyroid, pituitary, adrenal or other glands
- ☐ None of the above

SECTION VI. MEDICAL QUESTIONS (cont'd)

In answering the questions in this application, do no include any medical history or information related to genetic testing, services or counseling. Also, do not include any information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.

Give full details in Section VII: ADDITIONAL MEDICAL INFORMATION for each question checked below. Each question must have at least one box checked – if none of the the conditions apply; you must check 'None of the Above' on each question.

In the past three (3) years have you been treated for or been told you had:

13. CIRCULATORY

- ☐ Angina, heart attack, myocardial infarction, arteriosclerosis, coronary artery disease, shunt placement and/or angioplasty
- ☐ Cerebrovascular accident (stroke) including transient ischemic attack (TIA)
- ☐ Chest pain, shortness of breath, heart murmur palpitation of the heart, rheumatic fever
- ☐ Heart bypass surgery, pacemaker implant
- ☐ Heart surgery
- ☐ High blood pressure
- ☐ Hemophilia
- ☐ Any other condition of the heart, blood, blood vessels or circulatory system
- ☐ None of the above

14. CANCER, LYMPHATIC SYSTEM, BLOOD, OR SKIN DISORDERS

- ☐ Anemia
- ☐ Cancer
- ☐ Hodgkin's disease
- ☐ Leukemia
- ☐ Melanoma, neoplasm or tumor
- ☐ Any other disorder of the lymphatic system
- ☐ Any other disorder of the skin
- ☐ None of the above

15. MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Chronic fatigue
- ☐ Connective tissue disorder
- ☐ Fracture(s) or broken bone(s) — Exposed bone? ☐ YES ☐ NO
- ☐ Fibromyalgia
- ☐ Lupus, systemic
- ☐ Any other disorder of the muscles, bones or joints
- ☐ None of the above

SECTION VI. MEDICAL QUESTIONS (cont'd)

In answering the questions in this application, do no include any medical history or information related to genetic testing, services or counseling. Also, do not include any information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.

Give full details in Section VII: ADDITIONAL MEDICAL INFORMATION for each question checked below. Each question must have at least one box checked – if none of the the conditions apply; you must check 'None of the Above' on each question.

In the past three (3) years have you been treated for or been told you had:

16. KIDNEY, URINARY, REPRODUCTIVE

- ☐ Abnormal pap smear
- ☐ Bladder or renal stones
- ☐ Dialysis
- ☐ Nephritis
- ☐ Nephrotic syndrome, renal disease or failure
- ☐ Sexually transmitted disease
- ☐ Sugar, blood or protein in urine
- ☐ Any other disorder of the reproductive organs, including prostate, ovaries or breasts
- ☐ None of the above

17. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE

- ☐ Anxiety, depression, emotional problems or nervous disorder
- ☐ Drug overdose
- ☐ Eating disorder
- ☐ Psychiatric treatment
- ☐ Any other mental, emotional disorder or situation
- ☐ None of the above

18. OTHER

- ☐ Current patient in a hospital or nursing home
- ☐ Sarcoidosis
- ☐ Any other implant(s), prosthetic device(s) internal fixation device(s) or retained hardware (i.e.. Pins, wires, screws, shunts, stents)
- ☐ Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder, or HIV
- ☐ Transplant recipient
- ☐ Surgery, procedure, or test advised by physician but not completed
- ☐ Unexplained or unintentional weight loss of 10 pounds or more
- ☐ Any injury deformity, incapacitation, disease or condition not listed elsewhere
- ☐ None of the above

SECTION VII. ADDITIONAL MEDICAL INFORMATION

1. Give full details to conditions checked in **Section VI, Questions 8-18**.
2. Include all treatments provided or planned that apply in the "Type of Treatment" section. Example treatments are:
   - Surgery Hospitalization
   - Emergency room visit
   - Chiropractic treatments
   - Nursing Home confinement
   - Doctor visits
   - Rehabilitation therapy (speech, physical, occupations)
3. Please ensure you include all the treatments that apply.
4. Indicate the name(s) that would have been given at the time of the physician visit-e.g. a maiden name.

NAME: _____

Question Number	Condition/Illness -and- Type of Treatment	Date of first Diagnosis		Date of Most Recent Visit		Total # of Visits	Degree of Recovery			Complete Name -and- Address of Physician
		MO	YR	MO	YR		None	Partial	Full	
15.	**Condition/Illness:** Arthritis **Type of Treatment:** Doctor Visit	8/10 **Mo Year**		6/12 Mo Year		8		X		Dr. XYZ 123 Any Street Any Place, AR
	Condition/Illness: Type of Treatment:	___/____ Mo Year		___/____ Mo Year						
	Condition/Illness: Type of Treatment:	___/____ Mo Year		___/____ Mo Year						
	Condition/Illness: Type of Treatment:	___/____ Mo Year		___/____ Mo Year						
	Condition/Illness: Type of Treatment:	___/____ Mo Year		___/____ Mo Year						
	Condition/Illness: Type of Treatment:	___/____ Mo Year		___/____ Mo Year						

SECTION VIII. PRESCRIPTION QUESTIONNAIRE

1. Are you currently taking any prescription medication, or have you taken prescription medication in the **last three (3) years**? ☐ YES ☐ NO

SECTION VII. ADDITIONAL MEDICAL INFORMATION

2. If you answered **YES**, please provide full details below. A print out from the pharmacy in **not** acceptable.

Name of Medication	Dosage	Specific Condition or Illness	Start Date (MM/YYYY)	Stop Date (MM/YYYY)	Degree of Recovery			Complete Name - and- Address of Physician
					None	Partial	Full	
Tylenol	1000 mg	Osteoarthritis	06/2008	Current	X			Dr. XYZ 123 Any Street Any Place, AR

SECTION IX: IMPORTANT INFORMATION FOR APPLICANT FORM

Carefully read and sign. Your application cannot be processed without this form being signed and returned.

Send no money with this application. You will be billed.

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. If, after purchasing this policy you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

IN SIGNING BELOW, I REPRESENT AND ACKNOWLEDGE

1. That I should not cancel any coverage I currently have until I am notified of QualChoice's decision.
2. An agent/broker involved in this insurance transaction may receive compensation from QualChoice for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent/broker.
3. If my application is accepted relying on my representations on this document, any coverage which may be issued to me shall be invalid if based on false information.
4. I agree any provider of medical services or supplies is authorized and directed to furnish QualChoice all records or copies thereof, relating to such services or supplies.
5. I authorize and release to QualChoice, Title XVIII Medicare claims information needed to coordinate benefits with this policy at any time I am eligible for Medicare benefits.
6. QualChoice may phone me for additional information that may help with the timely processing of my application.

IN SIGNING BELOW, I REPRESENT AND ACKNOWLEDGE

7. That the statements and answers given in this application and any signed and dated addenda to this application (both front and back) are true, complete and correctly recorded.
8. I have read and understand the **Important Information for Applicant** (Section IX).
9. I ACKNOWLEDGE my understanding that consistent with the requirements of the **Genetic Information Nondiscrimination Act of 2008**, QualChoice does not use genetic information for underwriting purposes or any other purpose prohibited by applicable law. I also acknowledge that QualChoice has requested that in answering the questions in the attached application I do not include any family medical history or information related to genetic testing, genetic services or genetic counseling. Also, QualChoice has requested that I do not include information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information. I further acknowledge that QualChoice has directed me to omit or remove from the attached application any genetic information.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

- I, the applicant, certify that I signed this application in the state of Arkansas.
- I, the applicant or my authorized representative, acknowledge receipt of the following:
  - ☐ ***Choosing A Medigap Policy: A Guide to Health Insurance for People with Medicare*** (available at www.medicare.gov/publications) and ***Outline of Medicare Supplement Coverage*** from QualChoice.

SIGNATURE OF APPLICANT	**DATE SIGNED** (MM/DD/YYYY)

FOR AGENT / BROKER ONLY

If application is being made through an agent/broker, he/she must complete the following:

I have read and understand the MediQ65® ***Application for Coverage***. I additionally certify that the applicant has received the *Choosing A Medigap Policy: A Guide to Health Insurance for People with Medicare* and the *Outline of Medicare Supplement Coverage* for the policy applied for and that the applicant has Medicare Parts A and B. The policy applied for will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage.

Before this form can be processed, the agent/broker's current health and life license must be on file with QualChoice. In addition, the agent/broker must be appointed with QualChoice.

AGENCY FEDERAL TAX ID # (IF APPLICABLE)	**AGENT/BROKER LICENSE #**	**PHONE NUMBER**
AGENT/BROKER PRINTED NAME	**AGENT/BROKER SIGNATURE**	**DATE SIGNED** (MM/DD/YYYY)

List below all health insurance policies you have issued to this applicant that are still in force and any other health insurance issued in the past five (5) years that are no longer in force and submit with this application as required.

NAME OF POLICY	NAME OF INSURANCE COMPANY	POLICY DATE (MM/DD/YYYY)	
		To	From

SECTION X: AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) FORM

Your application cannot be processed without this form being signed and returned.

1. I authorize any medical professional, medical care institution, other provider of health care services or supplies, the Medical Information Bureau (MIB), reinsurer, health plan, prior insurance carrier, consumer reporting agency, other third party medical and/or pharmaceutical databases or other organization, institution or person, that has any records on me or my health to provide QualChoice, any third party retained by QualChoice, or its reinsurers, information with respect to any physical or mental condition, treatment or any non-medical information on me.
2. I understand that information obtained as a result of this authorization will be used for the purpose of underwriting and determining eligibility for coverage.
3. This information shall also be used by QualChoice in investigating and adjudicating claims for benefits.
4. I understand that in the course of their business operations, QualChoice may disclose this information to others as required or permitted by law and as set out in the QualChoice ***Notice of Privacy Practices***.
5. I understand that information provided under this authorization if re-disclosed will no longer be protected. However, QualChoice and its associates are protected by federal and state privacy laws and regulations.
6. I specifically authorize QualChoice to release necessary information obtained by QualChoice about me to my broker/agent.
7. This authorization permits release of information related to substance use or abuse, but does not provide for the disclosure of psychotherapy notes as defined in 45 CFR § 164.501.
8. I acknowledge that signing this authorization is a condition of my enrollment for health coverage by QualChoice.
9. I understand that I may terminate this authorization by sending a written revocation to QualChoice, ATTN: MEDIQ65®, P.O. Box 25626, Little Rock, AR 72221-5626. However, if I revoke this authorization before I am enrolled in the MediQ65 policy, my application for coverage will be denied.
10. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims.
11. A photocopy of this authorization is as valid as the original.
12. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signature in Global and National Commerce Act 15 USC §§ 7001 et seq., the Arkansas Electronic Records and Signature Act A.C.A §§25-31-101 et seq. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i)
13. QualChoice may release any information obtained by it about me to MIB or any member company for purposes described in QualChoice's *Notice of Privacy Practices.*

PRINTED NAME OF APPLICANT	
SIGNATURE OF APPLICANT	DATE SIGNED (MM/DD/YYYY)

SECTION XI. PAYMENT AUTHORIZATION FORM

Use this form to select the type of payment method you want QualChoice to apply when billing your MediQ65® premium. Your application cannot be processed without this form being signed and returned.

Check (✓) one of the 3 payment methods below.

☐ **Bank Draft (Monthly).** I authorize QualChoice and the Bank/Financial Institution indicated below, to debit my MediQ65® premium from the account indicated below. This authority is to remain in full force and effect until my Bank has received written notification from me of the Bank Draft termination in such time and such manner as to afford the Bank a reasonable opportunity to act on it, or until the Bank has sent me ten (10) days' written notice of the Bank's termination of this agreement. I understand that by revoking the Bank Draft after I have agreed to it, I will also be terminating my MediQ65® coverage, UNLESS QualChoice has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the Bank Draft withdrawal date. I understand that if my bank rejects a draft due to insufficient funds in my account, QualChoice may charge me a fee of up to $20.00. In order to use Monthly Bank Draft as my payment method, I understand that I must submit this form to QualChoice and staple a blank check marked VOID in the top left-hand corner of this form. My first month's premium will be drafted upon initial acceptance of coverage. For all other premiums I may select one of two bank draft dates.

I understand and agree that my first month's premium will be drafted upon initial acceptance of coverage.

PLEASE CHECK ONE: For all other bank drafts I have checked (✓) below the preferred date. **Example**: Premiums due in January coverage month can be drafted on the 24th of December or the 5th of January.

☐ **24th of the month preceding the coverage month** -or- ☐ **5th of the coverage month**

Name Of Bank Or Financial Institution	Account Type (Check One) ☐ Checking ☐ Savings
Bank Account Number	9 Digit Bank Routing No.
Account Holder Name	Account Holder Address (Street, City, State, Zip)
Account Holder Signature	Date Signed (MM/DD/YYYY)

☐ **Monthly Billing ($2.00 monthly service fee applies).** Your monthly invoice will be mailed to your Billing Address as listed in Section I.

☐ **Quarterly Billing.** I authorize QualChoice to bill my MediQ65® premium on a quarterly basis. This type of billing arrangement is to remain in full force and effect until QualChoice receives written notice of my desire to change my billing arrangement. I must provide QualChoice notice to change my billing arrangement twenty (20) days prior to when my next premium payment is due. In order to use quarterly billing as my payment method, I understand that I must submit this form to QualChoice.

By signing this PAYMENT AUTHORIZATION FORM, I agree to all terms and conditions expressed in the payment method I have chosen above. I understand that not properly following what has been authorized on this form may cause my MediQ65® policy to be terminated at QualChoice's discretion.		
Printed Name of Applicant	**Signature of Applicant**	**Date Signed** (MM/DD/YYYY)

DISCLAIMER

MediQ65® Medicare Supplement plans are not connected with or endorsed by the U.S. Government or the Federal Medicare program.

FAIR CREDIT REPORTING ACT NOTICE

Notice to Proposed Insured

Please keep for your records.

In connection with your application for insurance an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to:

QualChoice MediQ65®
Underwriting Division
PO Box 25626
Little Rock, AR 72221-5626

Quick Checklist

Complete, sign and return the following forms in the enclosed postage-paid return envelope.

- ☐ **Application for Coverage**
- ☐ **Important Information for Applicant Form**
- ☐ **Authorization to Disclose PHI Form**
- ☐ **Payment Authorization form**
- ☐ **Attach check marked VOID if selecting Monthly Bank Draft**

FOR MORE INFORMATION ABOUT MEDICARE AND MEDIGAP

MediQ65 Medicare Supplement Plan — Weekdays 8 a.m. to 5 p.m. Central Time

Toll Free 1.855.MEDIQ65 (1.855.633.4765)
www.mediq65.com

Senior Health Insurance Information Program (SHIIP – State of Arkansas) provides free one-on-one counseling, education, and information to individuals with Medicare of all ages.

Toll Free 1.800.224.6330 or 501.371.2782
www.insurance.arkansas.gov

Medicare — 24 hours a day, 7 days a week

Toll Free 1.800.633.4227 (1.800.MEDICARE) • TTY/TDD users call 1.877.486.2048
Choosing A Medigap Policy: A Guide to Health Insurance for People with Medicare available at www.medicare.gov/publications